# Office Billing

**By David Belk MD**

Do you know how much your doctor gets paid to see you? You probably don't but, what if I told you most doctors don't know how much they're paid to see a patient either?

Take a moment to think about that: not only does your doctor have no idea how much you might pay for the medications he prescribes you or how much that test he ordered for you will cost, he doesn't even know how much he's paid to see you in his office. If you didn't think medical finances in this country were surreal before, that should convince you.

Why don't doctors know how much they're paid to see patients?

The methods in which insurance companies pay doctors are varied, convoluted and rather opaque. I say this as the owner of a private practice who does his own billing. As examples:

1. Different insurance companies will pay doctors a different amount for the same billing code.

2. The same insurance company will also pay a doctor a different amount for the same billing code depending on the type of policy a patient has.

3. There is almost no way to find out how much an insurance company might pay for an office visit in advance.

4. It's not always easy to figure out how much insurance companies have paid us in the past for office visits.

5. Different insurance companies will approve and disapprove of different services, so it's difficult to know in advance what we'll be paid for.

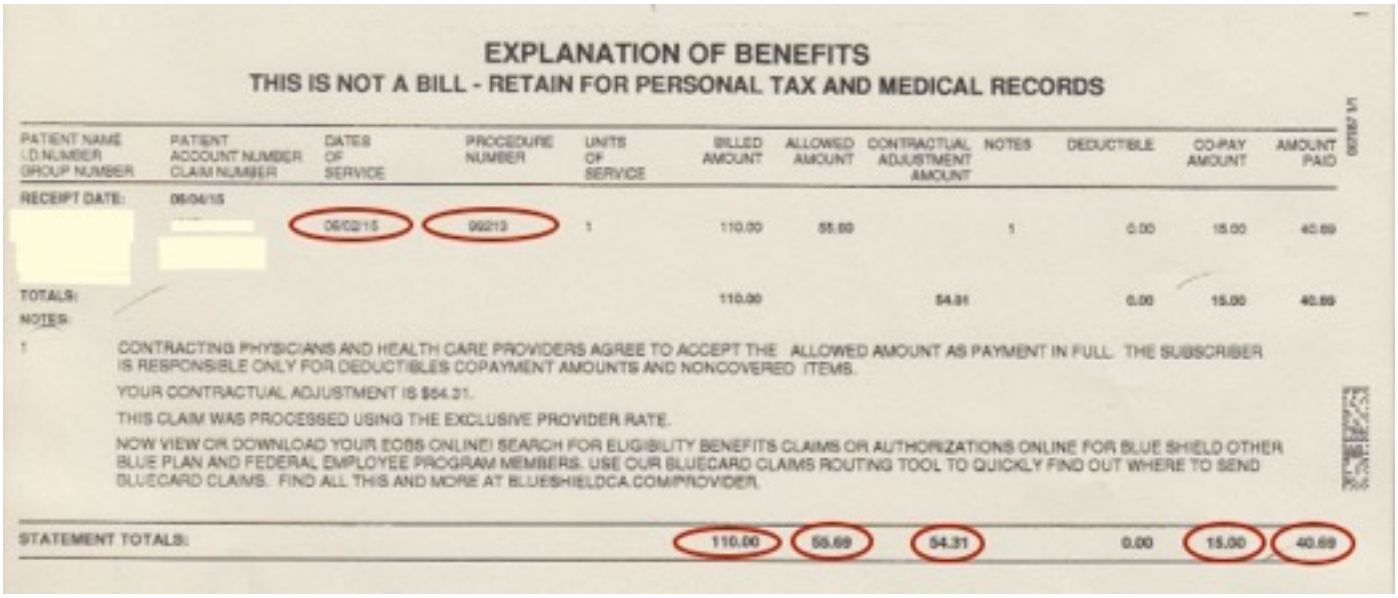
6. The same insurance company might have several different methods of payment depending on the patient's type of policy.

OK, that's quite a list but I'll explain each point individually. Before I do, though, I'll introduce you to what an explanation of benefits (EOB) is. An EOB is a statement each insurance company sends each medical provider every time that provider bills for a service.

Here's how EOBs work:

If a healthcare provider—hospital, lab, physician, whoever—provides a medical service and bills the patient's insurance company, the insurance company will respond with an EOB. The EOB explains what service we are paid for, how much we will be paid, who pays (the patient or the

insurance company) and what was denied or not allowed. Maybe there'll also be a check, but not only will the amount be less than what was billed (remember the amount billed is almost always inflated), it will usually be less than what the insurance allows.



EXPLANATION OF BENEFITS

THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

| PATIENT NAME / I.D.NUMBER / GROUP NUMBER | PATIENT ACCOUNT NUMBER / CLAIM NUMBER | DATES OF SERVICE | PROCEDURE NUMBER | UNITS OF SERVICE | BILLED AMOUNT | ALLOWED AMOUNT | CONTRACTUAL ADJUSTMENT AMOUNT | NOTES | DEDUCTIBLE | CO-PAY AMOUNT | AMOUNT PAID |
|---|---|---|---|---|---|---|---|---|---|---|---|
| RECEIPT DATE: 06/04/15 | | | | | | | | | | | |
| | | 06/02/15 | 99213 | 1 | 110.00 | 55.69 | | 1 | 0.00 | 15.00 | 40.69 |
| TOTALS: | | | | | 110.00 | | 54.31 | | 0.00 | 15.00 | 40.69 |

NOTES:

1 CONTRACTING PHYSICIANS AND HEALTH CARE PROVIDERS AGREE TO ACCEPT THE ALLOWED AMOUNT AS PAYMENT IN FULL. THE SUBSCRIBER IS RESPONSIBLE ONLY FOR DEDUCTIBLES COPAYMENT AMOUNTS AND NONCOVERED ITEMS.

YOUR CONTRACTUAL ADJUSTMENT IS $54.31.

THIS CLAIM WAS PROCESSED USING THE EXCLUSIVE PROVIDER RATE.

NOW VIEW OR DOWNLOAD YOUR EOBS ONLINE! SEARCH FOR ELIGIBILITY BENEFITS CLAIMS OR AUTHORIZATIONS ONLINE FOR BLUE SHIELD OTHER BLUE PLAN AND FEDERAL EMPLOYEE PROGRAM MEMBERS. USE OUR BLUECARD CLAIMS ROUTING TOOL TO QUICKLY FIND OUT WHERE TO SEND BLUECARD CLAIMS. FIND ALL THIS AND MORE AT BLUESHIELDCA.COM/PROVIDER.

| STATEMENT TOTALS: | 110.00 | 55.69 | 54.31 | 0.00 | 15.00 | 40.69 |
|---|---|---|---|---|---|---|

**Figure 1:** Here's an example EOB from Blue Shield:

This is for a patient I saw on June 2, 2015 for a follow up office visit. There is a lot of confusing information on this document but, bear with me and I'll walk you through it all.

Under the heading "procedure number" (to the right of "dates of service") you see the number 99213. A 99213 is the insurance code for "follow up office visit, low complexity" meaning that I've seen this patient before, I'm seeing her again today, but not for anything very complicated.

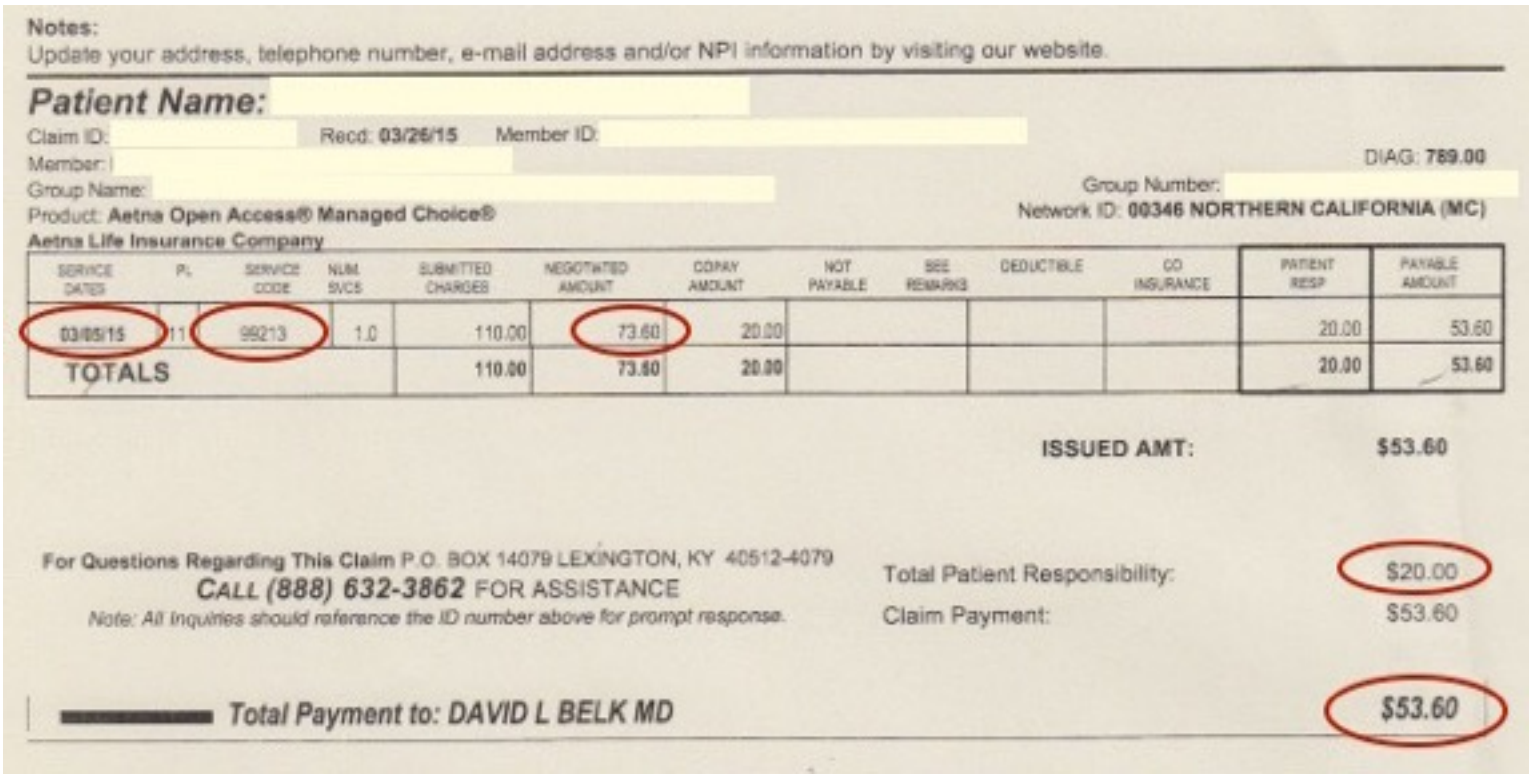
Going further to the right, you can see that I billed Blue Shield $110, the allowed amount in the next column was $55.69 and the contractual adjustment was $54.31. That means that Blue Shield has no intention of paying me the $110 I billed for that patient's visit. They'll allow me to collect $55.69 and I can forget about the remaining $54.31.

What's more, Blue Shield is only responsible for $40.69 of the $55.69 they approved. The patient already paid me a $15 copay. So the EOB provides both a partial payment (if I'm lucky) as well as a set of guidelines for how I might collect the rest of what they say I'm owed.

As you can already see, the insurance companies have created a rather confusing process for collecting an amount of money that, in many cases, would barely be enough to fill the gas tank of an SUV.

Now that I've shown you what an EOB looks like, let's go over a few more.

Below is one from Aetna which shows that I was allowed to receive $73.60 for a 99213 (again follow up visit, low complexity) in March of 2015. $53.60 of that was paid by Aetna and $20 by the patient.



Notes:
Update your address, telephone number, e-mail address and/or NPI information by visiting our website.

**Patient Name:**

Claim ID: Recd: 03/26/15 Member ID:
Member:
Group Name:
Product: Aetna Open Access® Managed Choice®
Aetna Life Insurance Company

DIAG: 789.00
Group Number:
Network ID: 00346 NORTHERN CALIFORNIA (MC)

| SERVICE DATES | PL | SERVICE CODE | NUM SVCS | SUBMITTED CHARGES | NEGOTIATED AMOUNT | COPAY AMOUNT | NOT PAYABLE | SEE REMARKS | DEDUCTIBLE | CO INSURANCE | PATIENT RESP | PAYABLE AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 03/05/15 | 11 | 99213 | 1.0 | 110.00 | 73.60 | 20.00 | | | | | 20.00 | 53.60 |
| TOTALS | | | | 110.00 | 73.60 | 20.00 | | | | | 20.00 | 53.60 |

ISSUED AMT: $53.60

For Questions Regarding This Claim P.O. BOX 14079 LEXINGTON, KY 40512-4079
CALL (888) 632-3862 FOR ASSISTANCE
Note: All inquiries should reference the ID number above for prompt response.

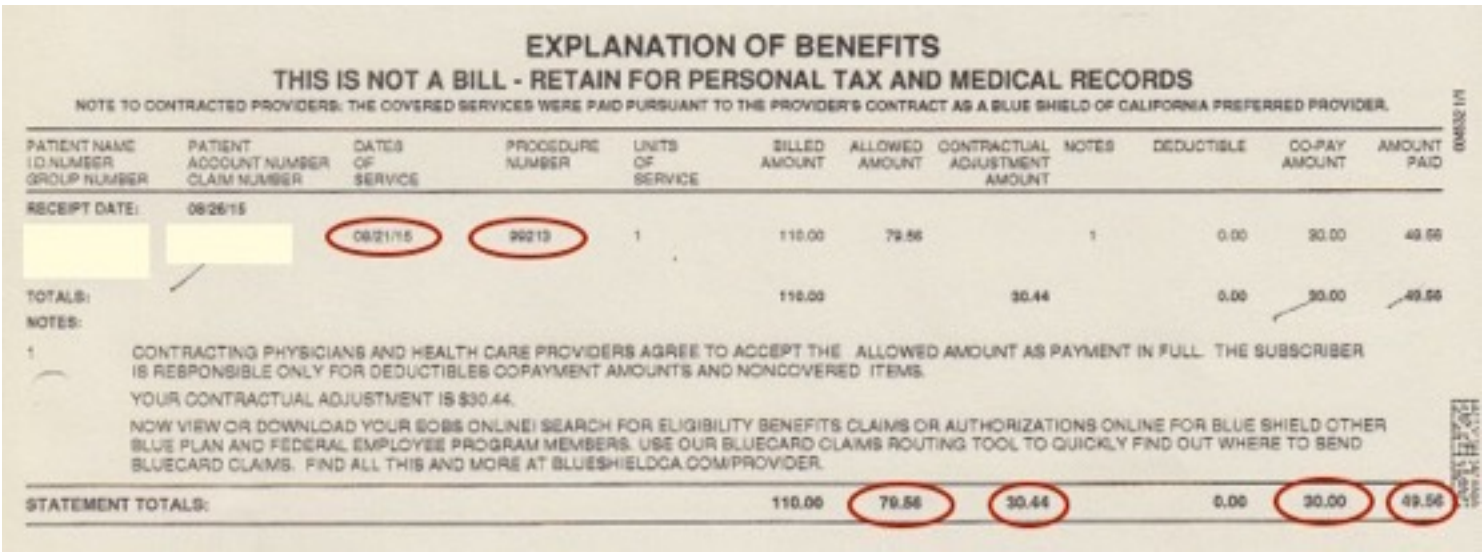
Total Patient Responsibility: $20.00
Claim Payment: $53.60

Total Payment to: DAVID L BELK MD $53.60

**Figure 2:** EOB from Aetna.

United Health let me have $68.74 for a 99213 in July 2015 ($25 from the patient and $41.26 from United Health) and Blue Cross allowed $74.79 for a 99213 also in July 2015.

So you can already see that each different insurance company is paying me a different amount for the exact same service. But it's actually more complicated than that. Here is another EOB from Blue Shield for a patient I saw on August 21, 2015. Again, I billed a 99213 (same billing code as in the other examples) but this time, Blue Shield allows me to get $79.56, which is $15 more than they allowed for the patient in the first example. What's more, that extra $15 came out of the patient's pocket (as a higher copay) and not Blue Shield's.



## EXPLANATION OF BENEFITS

### THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

NOTE TO CONTRACTED PROVIDERS: THE COVERED SERVICES WERE PAID PURSUANT TO THE PROVIDER'S CONTRACT AS A BLUE SHIELD OF CALIFORNIA PREFERRED PROVIDER.

| PATIENT NAME / ID NUMBER / GROUP NUMBER | PATIENT ACCOUNT NUMBER / CLAIM NUMBER | DATES OF SERVICE | PROCEDURE NUMBER | UNITS OF SERVICE | BILLED AMOUNT | ALLOWED AMOUNT | CONTRACTUAL ADJUSTMENT AMOUNT | NOTES | DEDUCTIBLE | CO-PAY AMOUNT | AMOUNT PAID |
|---|---|---|---|---|---|---|---|---|---|---|---|
| RECEIPT DATE: | 08/26/15 | | | | | | | | | | |
| | | 08/21/15 | 99213 | 1 | 110.00 | 79.56 | | 1 | 0.00 | 30.00 | 49.56 |
| TOTALS: | | | | | 110.00 | | 30.44 | | 0.00 | 30.00 | 49.56 |

NOTES:

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YOUR CONTRACTUAL ADJUSTMENT IS $30.44.

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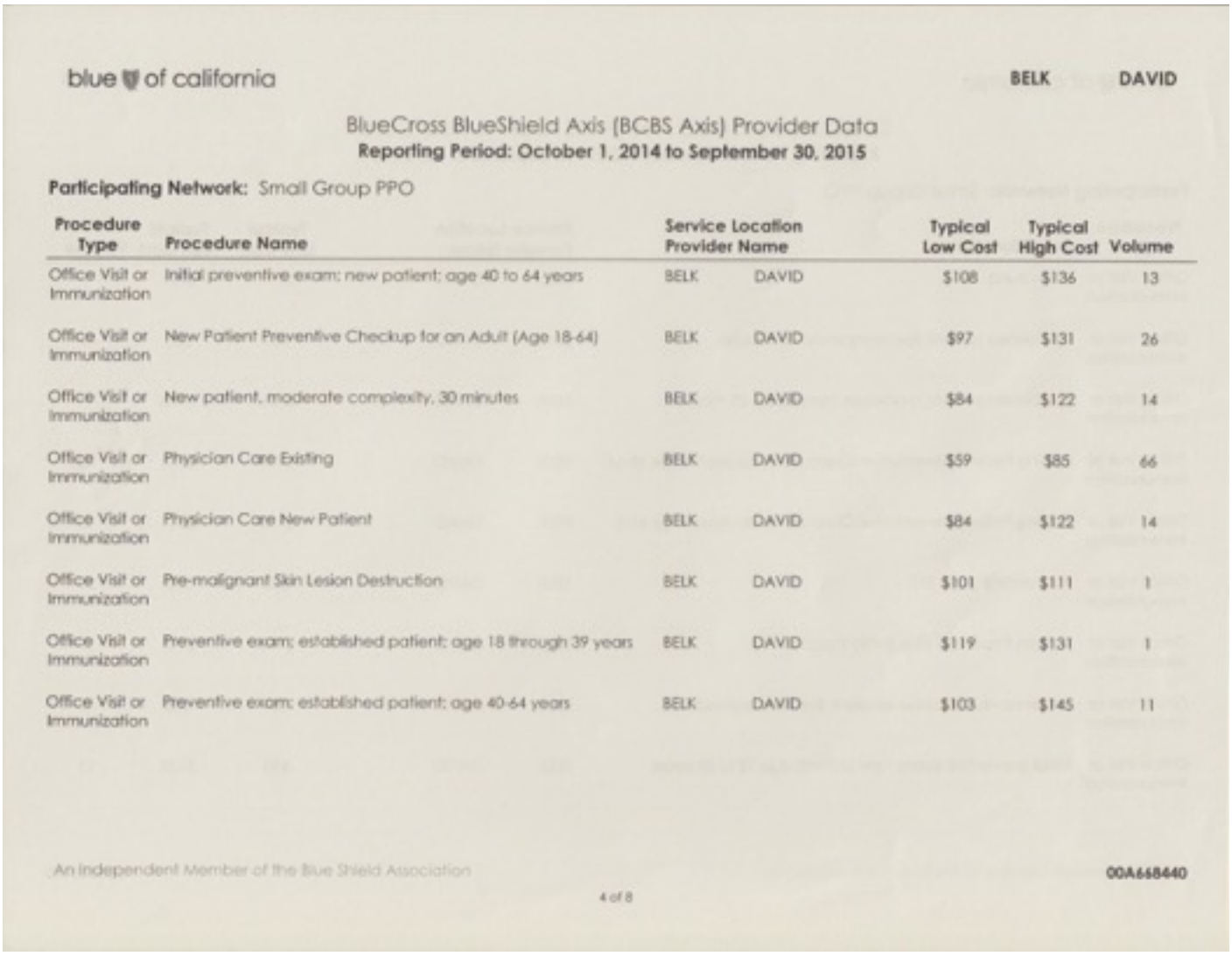
| STATEMENT TOTALS: | 110.00 | 79.56 | 30.44 | 0.00 | 30.00 | 49.56 |
|---|---|---|---|---|---|---|

**Figure 3**

OK, What's going on?

The patient in the first example had an EPO plan whereas the patient in the second example had a PPO plan. In fact, Blue Shield recently sent me this table explaining the range of payments they offer doctors for each listed service:



blue of california BELK DAVID

BlueCross BlueShield Axis (BCBS Axis) Provider Data
**Reporting Period: October 1, 2014 to September 30, 2015**

**Participating Network:** Small Group PPO

| Procedure Type | Procedure Name | Service Location Provider Name | | Typical Low Cost | Typical High Cost | Volume |
|---|---|---|---|---|---|---|
| Office Visit or Immunization | Initial preventive exam; new patient: age 40 to 64 years | BELK | DAVID | $108 | $136 | 13 |
| Office Visit or Immunization | New Patient Preventive Checkup for an Adult (Age 18-64) | BELK | DAVID | $97 | $131 | 26 |
| Office Visit or Immunization | New patient, moderate complexity, 30 minutes | BELK | DAVID | $84 | $122 | 14 |
| Office Visit or Immunization | Physician Care Existing | BELK | DAVID | $59 | $85 | 66 |
| Office Visit or Immunization | Physician Care New Patient | BELK | DAVID | $84 | $122 | 14 |
| Office Visit or Immunization | Pre-malignant Skin Lesion Destruction | BELK | DAVID | $101 | $111 | 1 |
| Office Visit or Immunization | Preventive exam; established patient: age 18 through 39 years | BELK | DAVID | $119 | $131 | 1 |
| Office Visit or Immunization | Preventive exam; established patient: age 40-64 years | BELK | DAVID | $103 | $145 | 11 |

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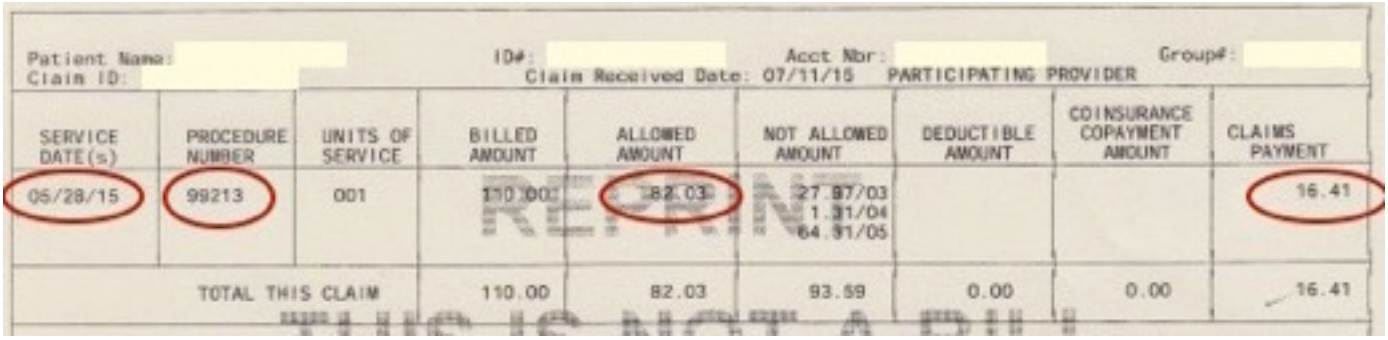
**Figure 4:** Range in some of Blue Shield's payments.

Does that make any sense to you at all? if it doesn't, you're not alone. Now you're starting to understand why most doctors have no idea how much they're paid for an office visit.

This EOB from Blue Cross shows that they allowed $82.03 but paid me only $16.41. Why? That's a Medicare Supplemental policy, so Blue Cross was just paying 20% of Medicare's approved payment.



Patient Name:
Claim ID:
ID#:
Acct Nbr:
Group#:
Claim Received Date: 07/11/15 PARTICIPATING PROVIDER

| SERVICE DATE(s) | PROCEDURE NUMBER | UNITS OF SERVICE | BILLED AMOUNT | ALLOWED AMOUNT | NOT ALLOWED AMOUNT | DEDUCTIBLE AMOUNT | COINSURANCE COPAYMENT AMOUNT | CLAIMS PAYMENT |
|---|---|---|---|---|---|---|---|---|
| 05/28/15 | 99213 | 001 | 110.00 | 82.03 | 27.97/03<br>1.31/04<br>64.91/05 | | | 16.41 |
| TOTAL THIS CLAIM | | | 110.00 | 82.03 | 93.59 | 0.00 | 0.00 | 16.41 |

**Figure 5:** Blue Cross Medicare Supplemental payment.

In fact Medicare's rates are actually as high or higher than the highest rate Blue Shield (or any other private insurance company) pays a doctor for an office visit:

| Encounter | Medicare Rate | Blue Shield Low Rate | Blue Shield High Rate |
|---|---|---|---|
| 99203 New Patient, 30 minutes | $121.76 | $84 | $122 |
| 99213 Follow Up, 15 minutes | $82.44 | $59 | $83 |
| 99214 Follow Up, 25 Minutes | $121.73 | $106 | $118 |
| Influenza Vaccination | $46.47 | $28 | $38 |

Incidentally, I did not negotiate with any insurance company for any of these rates, nor has any other doctor I know ever negotiated office payments with an insurance company. Also, as far as I know, all doctors in my area get paid the same as I'm paid by the insurance companies for each billing code.

Now, I haven't even mentioned deductibles or co-insurances, which we bill the patient for after we see them. These are determined by the insurance companies after we bill them, so the amount we bill the patient will be explained in the EOB.

There will also be services that will be listed as not allowed, which means we get nothing. These services will vary for different insurance providers. Also, when a service is denied or not covered (which is different from a service that's not allowed) or, if the patient is out of network, we're expected to bill the patient for the full billing charge, which is always far more than the amount any insurance company would pay us for that service. Since most doctors have little knowledge or understanding of which networks we belong to or why, that can be especially confusing.

I should also note that the terms I define here a not really universal. Different insurance companies might use different terms for the situations I'm describing so, "not allowed" for one insurance company might mean the same as "denied" for another, and so on. Insurance companies compensate for these differences by sending attached explanations to explain each explanation of benefits, though.

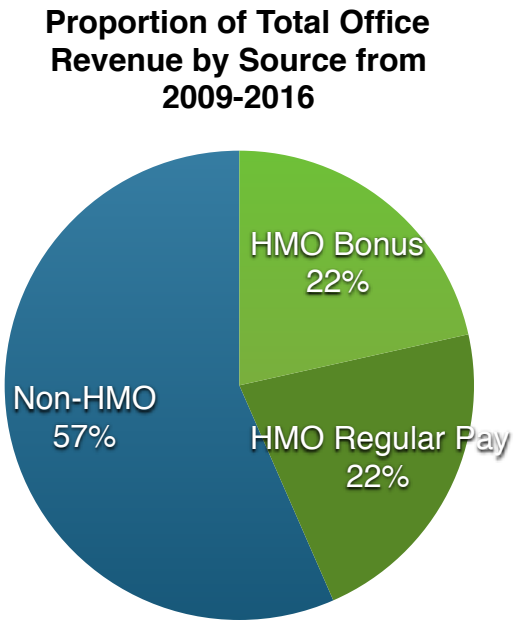
**But it gets even better.**

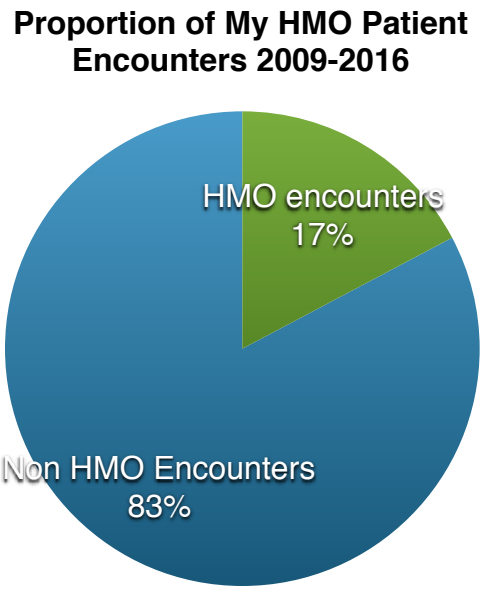
If a patient has an HMO instead of a PPO or EPO then the doctor isn't really paid for an office visit at all. Instead, doctors get a monthly stipend called a capitation for each HMO patient who chooses that doctor. The amount the doctor gets as a capitation for each patient varies based on the age and sex of the patient as well as other factors like whether or not they have Medicare.

We still collect copays from HMO patients, which can range anywhere from $5-$45, but the copay is all we get for the visit itself and has nothing to do with how much time is spent with the patient or what's done.

What's even more bizarre is the fact that much of the money HMOs pay me isn't even from the capitations or office copays. Roughly half of my HMO pay, and 20% of my total office income comes from HMO bonuses. These bonuses usually come randomly and without explanation about twice each year.

So, in reality, HMOs are my highest payers by far. In fact, the HMOs pay me more than twice as much, on average, for each HMO patient I see as the other types of insurance providers pay me. Since 2009, 42% of my total office revenue came from HMO payments (including bonuses) even though only 18% of the patients I saw had an HMO policy.



F**igure 6:** (Above) my HMO revenue compared to my HMO traffic.

As you can see from those graphs, A good portion of my total office revenue each year doesn't even come from seeing patients. Also, HMOs are obviously not about saving money.

Now most doctors aren't aware of much of what I've explained here for two reasons:

1. The system is far too confusing for even doctors to understand clearly and

2. Most doctors don't even do their own billing. Instead, they simply hire a billing agency to do their billing for them. Doctors will give the agency a summary of the patients they saw along with the diagnosis and encounter codes, and the service takes care of all of the billing and gives the doctor a check each month based on what was collected.

**Why do doctors over bill for their services?**

Doctors, along with all other heath care providers, virtually always bill insurance companies far more than what we would expect in payments. Why? The simple answer is that we usually don't know what to expect.

Insurance companies will always pay what ever a medical provider bills up to the maximum amount they're willing to pay for any service. So, if a doctor bills $100 for an office visit, and the insurance company is willing to pay $75, the doctor will get $75. If the doctor bills only $60 for that office visit then $60 is all he'll receive.

There is absolutely no penalty in health care for over billing, but any medical provider who under bills will short change themselves. This is why billing charges have exploded by so much in health care. This payment system is far too confusing for any health care provider to really understand, so the best strategy is to bill high for every service then take what they give us.

This creates a huge problem for anyone who is uninsured, but an even bigger problem for people who have insurance and had their claim denied for any reason. The uninsured will be forced to negotiate on their own behalf against billing charges that might be many times the value of a medical service. This puts the uninsured at a severe disadvantage. A person who uses their insurance, but has their claim denied is almost always expected to pay the full bill, though. They aren't even allowed to try to negotiate.

This section should make it obvious that doctors have very little influence on, or even understanding of the process by which we are paid. The insurance companies have effectively excluded us from understanding the source of our own incomes. This clearly shows the degree to which health insurance companies have almost complete and unchecked control over the finances of health care in this country. If that doesn't worry you, it should.